SUMMIT PACIFIC

MEDICAL RECORD REQUEST or RELEASE

600 East Main Street, Elma, WA 98541
Fax your requests to 360-346-2216; fax patient records to 360-346-2161
Grays Harbor County Public Hospital District No. 1

Patient Information

Name: _____ **DOB:** _____

Address: _____ **City:** _____

State:_____ **Zip:** _____ **Home Phone:** _____and/or **Cell Phone:** _____

Name of Clinic, Hospital, or Healthcare Provider—*Who has the information the patient wants released?*

Name: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____ **Fax Phone:** _____

Receiving Party— *Where do you want the information sent? Who may have the information?*

Name: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____ **Fax Phone:** _____

Deliver Method for Request: ☐ **PICK-UP** ☐ **MAIL** ☐ **FAX**

Information to be Released—*What do you want sent or released?*

I understand that the protected health information (PHI) I am requesting may include disclosure of information regarding HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or mental illness. I authorize the release or disclosure of this information unless I check the box below. Please note that this form **will not** be used to disclose psychotherapy PHI.**I do NOT want any information relating to**:

☐HIV/AIDS, ☐sexually transmitted disease, ☐ drug and/or alcohol or ☐ mental illness disclosed.

Please release the following (check all that apply):

☐ Clinic Records* ☐ Labs ☐ Radiology Reports/Films ☐ Consult Reports ☐ All Medical Records (<50 pages)
☐ Billing Records ☐ All Vaccinations/Immunizations ☐ EKG's ☐ Special Tests
☐ Recent 2 years of physician reports (no more than 50 pages)
☐ Other (Specify):_____

***** SPMC wants to receive only the last two years of records for Transfer of Care not to exceed 50 pages. **Fax to 360-346-2161**

Indicate date(s) of service or event _____

This authorization expires in one year unless specified.

Purpose of Release – *Why is this information needed?*

☐ Transfer of Care ☐ Personal ☐ Legal ☐ Continuity of Care ☐ Other* _____

Consent—*Approval for Release of Records*

By signing this this Request of Information, I give my authorization for the records designated to be released as directed above.

If patient has reached his/her thirteenth (13th) birthday, and has consented to treatment, **ONLY** the patient can authorize disclosure relating to HIV/AIDS, Sexually Transmitted Diseases, Drug and/or Alcohol Abuse, Mental Illness.

I understand the following: See CFR §164.502(c)(2)(i-iii) I have a right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization. I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Information disclosed under this authorization might be re-disclosed by the recipient and the re-disclosure may no longer be protected by federal, state or privacy laws. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay (RCW70.02.080). I understand that I have a right to receive a copy of this authorization.

Signature: _____ **Relation(If not self)** _____ **Date:** _____

☐ **ID Checked** *(Driver's License, Military ID, Photo ID, SS Card)* **SPMC Registration Initials:**_____ **SPMC HIM Staff Initials:**_____